

**Services:**  
Infant Development  
Family Development  
Occupational Therapy  
Physiotherapy  
Speech-Language Therapy  
Supported Child Development



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## REFERRAL FORM

Referral Date: \_\_\_\_\_

Has parent/guardian been informed and agree to referral?  Yes  No (If no, this referral cannot be processed)

Does parent/guardian require an interpreter?  Yes  Parent/guardian consents to being contacted by interpreter

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Care Card #: \_\_\_\_\_ Pediatrician(s): \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Address/Clinic: \_\_\_\_\_

Address/Clinic: \_\_\_\_\_

Child's Address (if different than below) \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Alternate: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Alternate: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Reason for Referral:

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Information taken by: \_\_\_\_\_

Referral Source: \_\_\_\_\_/Parent

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

For Office Use Only

NOR  NOR CEN  SOU CEN  SOU

Initial IC/DC

External

Assigned to \_\_\_\_\_

